structions; HDRS total score was correlated to the score in each SF-36 dimension using Pearson correlation coefficients. Mean scores of the two categories (depressed, not depressed) were compared with the norm using analysis of covariance allowing for effects due to age.
RESULTS: Forty specialists enrolled 663 pts (653 fully evaluable). Mean age was 35, mean age at diagnosis was 19. Duration of untreated migraine ranged from 4 to 72 hours (82% of pts); migraine was severe in 57.3% of cases, and throbbing in 78.9%. HDRS scores revealed a prevalence of depression of 38.9% (HDRS score greater than 7) among them, although 53.7% suffered from minor depression. Correlations between HDRS and SF-36 dimensions ranged, in absolute value, from 0.37 to 0.67. All SF-36 mean scores of depressed pts were significantly lower than the norm ($P < .01$). Among not depressed pts, four out of eight mean scores are significantly lower than norm ($P < 0.01$).
CONCLUSION: Results of our survey suggest that a number of women suffering from menstrual migraine are depressed. A significant role in worsening QoL is played by depression.

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COST-EFFECTIVENESS OF THERAPY FOR RELAPSING-REMITTING MULTIPLE SCLEROSIS (RRMS): INTRODUCING AN ECONOMIC MODEL FOR COPAXONE (GLATIRAMER ACETATE)

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MS is the most common neurological disorder among young adults affecting around 85,000 people in the UK. Copaxone is a non-interferon disease-modifying agent, indicated to reduce the frequency of relapses in ambulatory patients with active RRMS.
OBJECTIVE: Demonstrate cost-effectiveness based upon proven economic methodologies.
METHODS: An economic model was developed based on available data (published efficacy over two and six years and data on file over eight years) for Copaxone. Direct medical and caregiver costs were taken from the published literature. The annual cost of Copaxone is £6,650. Rather than modeling based upon a hypothetical cohort, the analysis was developed using patient data from the trial where possible. The model utilizes the core endpoints of the trial, including number of relapses, disability burden via EDSS (Expanded Disability Status Scale) at each study visit, percentage of patients with improved EDSS, patients without worsening of EDSS, and without sustained progression.
RESULTS: Based upon analysis over eight years, cost per relapse avoided and cost per disability unit avoided were £11,208 and £9,035 respectively. Dependent on the assumption regarding utility loss during a relapse (two months with utility loss of 0.083, or six months with a utility loss of 0.4, and a factor for severity of relapse) the cost per QALY was between £65,896 and £23,026 respectively. Sensitivity analysis showed these results were most influenced by changes in the duration of analysis, utility loss of relapse, and cost of therapy.
CONCLUSIONS: Previous cost-effectiveness analyses for Copaxone reported in the literature assumed parity price with the beta-interferons, and did not incorporate new evidence of long-term efficacy. Using this new information, the reported cost-per-QALY ratio is favourable compared to accepted standards for cost-effectiveness in the UK. This analysis provides economic justification for the prescribing of Copaxone to appropriate patients with RRMS.